Identifying Perspectives on Barriers and Needs of Spanish Language Speakers in Idaho's Healthcare System

Insight from Focus Groups with Spanish Speaking Patients Utilizing Language Services in Southwest Idaho

Final Report

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Background

In August 2001, President Clinton issued Executive Order 13166, "*Improving Access to Services to Persons of Limited English Proficiency*." The purpose of the Executive Order was to improve access to federally-conducted and federally-assisted programs for limited English proficient (LEP) persons. Health providers in Idaho struggle to comply with this order and numerous studies and demonstration projects have been conducted to ensure that all persons with limited English proficiency could access health services with varying results.

The mission of the Idaho State Office of Rural Health and Primary Care (SORH) is to promote access to quality health care for people in Idaho. The office supports its mission through a variety of programs, partnerships, services, and activities. Three independent organizational partners designed, conducted and interpreted the results for this focus group project. The Centro de Comunidad Y Justicia (Center for Community and Justice/CCJ) is a community-based organization that works in the area of providing support and technical assistance to the Hispanic communities of Idaho. Idaho State University (ISU) is one of four state-funded four-year institutions in the state of Idaho. It is home to the Kasiska College of Health Professions and has the distinction of having the only Council on Education for Public Health (CEPH) accredited Master of Public Health program in Idaho. Health Fit Designs is an independent consulting firm that specializes in designing health promotion programs and interventions.

This project, "Identifying Perspectives on Barriers and Needs of Spanish Language Speakers in Idaho's Healthcare System", provides insight from Spanish-speaking patients who had utilized language services in Southwest Idaho. These two focus groups were conducted in Fruitland and Nampa, Idaho. The focus groups were conducted in Spanish by El Centro de

Comunida Y Justicia (CCJ) and the results were analyzed by ISU and Health Fit Designs through a contract with the State Office of Rural Health and Primary Care.

Introduction

Language and culture directly and indirectly affects communication between patients and healthcare providers. Usually, culture and language communication barriers exist simultaneously, and can have a direct impact on patient health outcomes. Miscommunication between patients and providers can result in obtaining incomplete or inaccurate medical history. A patient's normative cultural values may result in inefficient communication and can result in medical errors, inaccurate behavioral strategies and inability of patients to follow through with their treatment.

Changing demographics, along with heightened federal and state policies, have increased the need for effective models of providing health care services to individuals who are limited English proficient (LEP). Unfortunately, many providers are challenged by a shortage of knowledge and resources, which can create barriers to care (Youdelman, M., Perkins, J. 2005).

In one state study (New Hampshire), it was found that the capacity to deliver language interpretation services varied widely from hospital to hospital. The most frequently used strategies in descending order were externally contracted interpreters, bilingual clinical staff, bilingual-non-clinical staff, and telephone services. The cost of scheduling interpreters and extended visit times were seen as barriers (Kohn, M., Stubblefied-Tave, B., and Siefert, R., 2005).

Locally in Idaho, a recent study of the Community Access Monitoring Survey (CAMS), conducted in 2001, compared the need for translation services in Idaho between two hospitals

and two clinics. Magic Valley Regional Medical Center (MVRMC), Mercy Medical Center (MMC), Terry Reilly Health Services (TRHS), and Family Health Services (FHS) were participants in this survey (Andrulis, D., An, C., and Pryor, C., 2001).

More MVRMC respondents (39%) than MMC respondents (24%) said they needed assistance with interpretation. However, among respondents who needed assistance, MMC respondents were more likely than MVRMC respondents to find interpreters readily available. More than half of the MVRMC respondents said that interpreter services were not readily available.

Although about one-third of each respondent group said they required assistance with interpretation, FHS respondents were somewhat more likely to report that interpreters were available. However for both groups, over 90 percent of respondents who received assistance said the ability of their interpreters was “very good” or “fair.”

In November 2006, the Idaho State Office of Rural Health and Primary Care (SORH) contracted with Idaho State University to conduct a survey of health care facilities to determine their perceptions of the effectiveness of linguistic services offered by their providers. These included acute care hospitals, critical access hospitals, certified rural health clinics and federally qualified health centers. This 2006 report, “Determining the Need and Effectiveness of Current Linguistic Services in Idaho’s Healthcare System” is available through the SORH. A total of 93 facilities received the survey and 57 responded, for an overall response rate of 61%. Highlights of those findings are presented on the next page.

Summary results include:

- Approximately 20,000 outpatient visits occur with LEP patients each month; this represents 16% of the total number of outpatient visits
- 56% of respondents have written policies for providing interpretive services
- 24% of respondents report their staff is highly aware of their facility's policy for providing interpretive services
- 9% of respondents always provide written follow-up instructions in a language the LEP patient can read
- 57% of respondents always provide verbal instructions in a language preferred by the LEP patient
- 27% of respondents have a method to conduct a formal assessment of the language needs of their service area
- 64% of respondents have official signage translated into Spanish
- 55% of respondents believe the demand for language services is growing

Summary recommendations for lead agency include:

- Develop a policy template for providing medical interpretive services in healthcare facilities
- Develop orientation training materials to increase awareness about policies and regulations related to medical language services
- Develop a tool for assessing service area language needs
- Provide cultural sensitivity training for healthcare organizations

Purpose of this Study

The purpose of the study was to identify the extent to which limited English proficient (LEP) users of healthcare services identify language as a barrier in receiving care. Because the previous study showed Spanish as the language most often encountered by health care facilities in Idaho, the two focus groups were conducted with LEP Spanish speakers (See Table 1 below). Although the results of this study are highly informative, it is the intent of the SORH to translate these findings into concrete actions and interventions to positively address any barriers that are identified.

Facility Type	Spanish	Other Languages
Acute Care Hospitals > 25 beds	83.1%	16.9%
Critical Access Hospitals	98.3%	1.7%
Certified Rural Health Clinics	98.6%	1.4%
Federally Qualified Health Clinics	97.6%	2.4%

Table 1: LEP Needs by Facility type

The goal of this project was to identify patients' perspective on effectiveness of language services in reducing communication barriers. Effectiveness in communication was measured in the areas of patient satisfaction, perceived health outcomes, access, health service utilization and potential for medical errors. Two focus groups were conducted based upon the population density of Hispanics in Idaho. The Nampa Hispanic population grew from 18% to 24% between 2000 and 2005. While 2005 figures were not available for Fruitland, the proportion of Hispanics in Fruitland in 2000 was 17.9%.

The estimated proportion of Hispanics in Idaho overall in 2005 is 9.1% (American Factfinder, US Census, accessed 3.21.07).

Limitations

While the focus group participants were selected from a larger sampling of interested individuals, it is recognized there is a natural bias in those who choose to participate in this type of study. The demographics of those selected to share their perspectives were primarily lower Socioeconomic Status (SES); their perspectives may have been shaded by access problems, thereby highlighting negative experiences, rather than positive ones. While the findings of this study are certainly important and provide insight into language services in Idaho's health care system, it is not intended to be representative of all encounters between LEP patients and the Idaho medical provider system.

Methods

Focus group participants were solicited through recruitment flyers in both Spanish and English. A selection criterion was set so that participants were adults with limited English proficiency who had visited a health care provider in the past 6 months. CCJ posted flyers in community centers and other public areas in the cities of Fruitland and Nampa. Participants received a small stipend to participate. Upon arriving at the focus group sites, all participants signed an informed consent, available in both languages (See Appendix B).

Theoretical Context

The Principal Investigator, in collaboration with the SORH, developed focus group questions with five thematic questioning strategies to help in identifying the scope and extent to which Spanish-speaking individuals identify language as a barrier to receiving health care services.

Five thematic questioning strategies:

1. **Patient satisfaction** –questions were asked about the general quality of last encounter with a health care provider.

2. **Language Access** –questions were asked about the efficiency of communication, type and preferred method of communicating.

3. **Health outcomes** – questions were asked on the effectiveness of the patient education material, preferred method of communication verbal vs. written.

4. **Potential for medical errors** – questions were asked about the perceived importance of translation services in improving communication between with health providers.

5. **Health service utilization** – questions were asked about delays, avoidance, or lack of access to needed medical services as a result of not having language services available.

The questions and probes used to elicit answers in the above areas are presented as Appendix C. Both sessions were audio-taped and verbatim transcription of the sessions was performed in Spanish. Two evaluators worked independently to analyze results in the context of the research questions to detect relevant themes. One used the verbatim text as transcribed in Spanish and the other used the text as transcribed into English. Participant comments were categorized into the five thematic areas prescribed above as a framework for analysis. Also, both examined the text for inappropriate or leading questions from the facilitator to eliminate as much biasing for interpreting answers as possible. When each evaluator completed their tasks, they discussed their findings and interpretations on March 24, 2007, with the SORH.

The interpretation of results used the Health Belief Model as analytical framework to provide context. The model posits that positive health behavior, in this case, the using of the

Idaho health care system, is predicted by the equation of Perceived Benefits minus Perceived Barriers yielding a positive remainder. These perceptions are functions of modifying factors, which include demographics, socio-psychological, cultural normative values, environmental dimensions as well as reinforcing or disempowering cues to action.

Health Belief Model

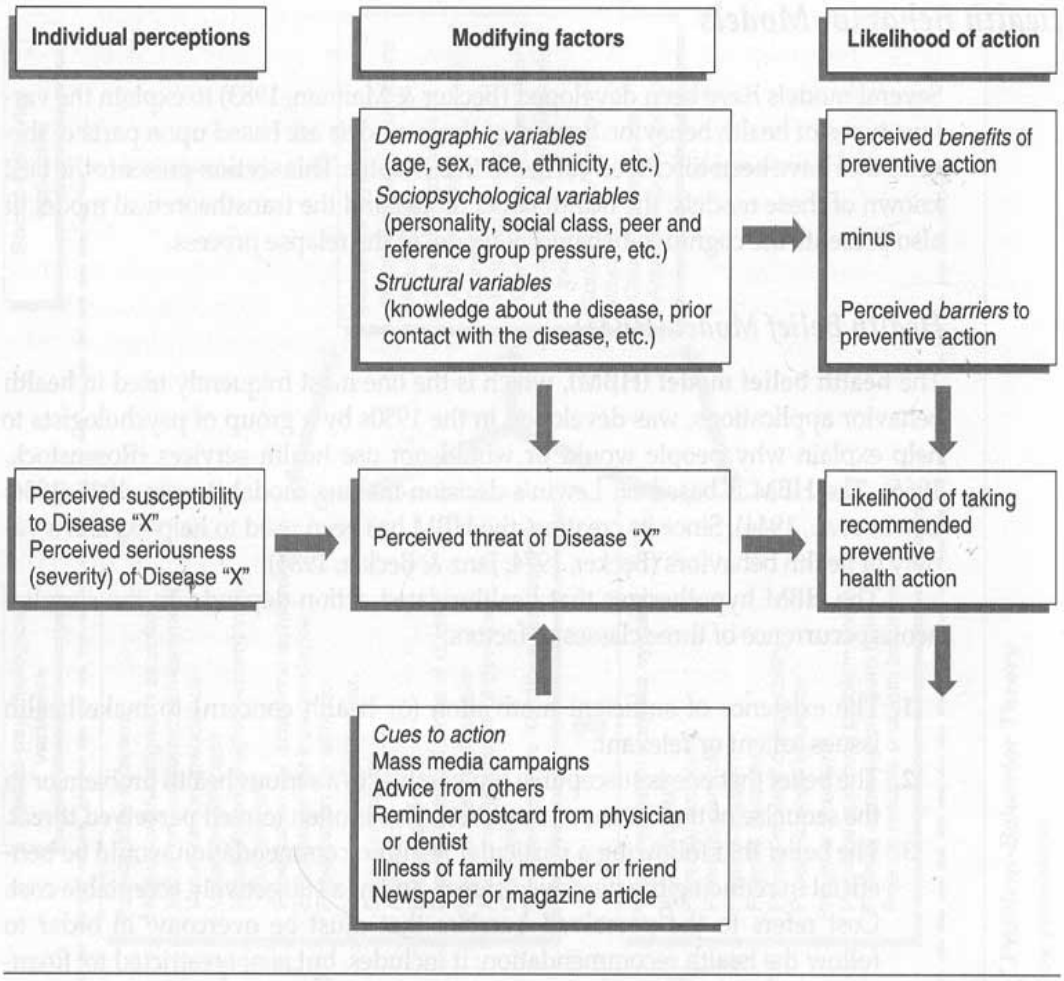

FIGURE 7.5 *The HBM as a Predictor of Preventive Health Behavior*

Source: M. H. Becker, R. H. Drachman, and J. P. Kirscht, "A New Approach to Explaining Sick-Role Behavior in Low Income Populations," *American Journal of Public Health, 64* (March 1974): 205–216. © 1974 American Public Health Association. Reprinted by permission.

Findings

The demographics of participants are provided in Table 2. The recruitment yielded 15 participants, split in half by gender. Ten of the 15 were married, 3 were single, one was divorced and one did not answer. One had some college education and the remainder had high school or primary school educations. Thirteen of the fifteen participants were born in Mexico. The approximate average age of the participant was 39.5 years old, and four of them had an income higher than $20,000 a year. Three of them made less than $10,000 a year.

Fruitland Site	Nampa site
February 9, 2007	February 10, 2007
4 adult males 4 adult females	3 adult males 4 adult females

Table 2: Demographics of Participants

Patient Satisfaction

A criterion for inclusion in this study was that the participant had the need to use language services and had an encounter with a health professional within the past 6 months. The perception of people with limited English proficiency on the effectiveness of language services in reducing communication barriers with a health care provider can give us clues on the delivery of care. William Osler, a Canadian physician once said that “the good physician treats the disease; the great physician treats the patient who has the disease” (as quoted in Eustice, 2007). While these words of wisdom ring true, patient centered care requires effective communication, having an understanding of the patient’s normative cultural values, and their experience of disease before illness.

While patient centered care is the ideal, an earlier study found that Spanish-speaking patients are at a double disadvantage in encounters with English-speaking physicians: these patients make fewer comments, and the ones they do make are more likely to be ignored. The communication difficulties may result in lower adherence rates and poorer medical outcomes among Spanish-speaking patients (Rivadeneyra, R, Elderkin-Thompson, V., Cohen Silver, R and Waitzkin, H, 2000).

It is impossible to separate the language barrier and the quality of encounter. Often, the terms "comfort" and "trust" are used to describe an encounter. The interpreter, good, bad or indifferent serves as a bridge for comfort and trust. The outcomes for "comfort" and "trust" are tied directly to the ability to communicate.

> *But, well, for me it was an experience where I felt like a lot of tension there. I felt like…I did not feel comfortable. I did not feel confidence (trust). In other words with regard to the interpreter it was very good but what I see as bad is that there are two for the entire clinic.*

The availability of an interpreter serves as a security blanket. As a direct link to the physician, the absence of, or the ineffectiveness of, an interpreter, adversely affects the quality of the entire medical encounter. A certain amount of "discomfort" associated with a medical encounter is the uncertainty of whether there will be an interpreter present.

> *I got here not long ago and well, I see that everything is good, right? In this country; I am comfortable and everything…..but when we are sick we choose and… I would rather stand it (the pain) than go (see a doctor). First…there was no interpreter... maybe now I have gone two-three times and there is (an interpreter). But when I went on Tuesday and a young*

> *woman, was very friendly, if I would get her. She is the one who greeted me. Then it was another one more like this. Then they went for the doctor, it was another one. It was three. Then the last one; the one with the doctor who checked me and everything.*

> *That is why I am telling you; I am comfortable here (in the US), but only if we do not get sick.…and then we got there and we could not find who could interpret for us. And the young woman who is there, the one who is there at the front doing the receptionist work…she would talk to me, well, in English and well I did not know anything, and with no way to answer her or anything…*

In the transcripts, we only found several instances where the quality of the medical encounter was positive. It is unfortunate that this line of questioning was not taken further; however, the deciding factor on whether that outcome was positive was the ability to communicate.

> *Yes. She was speaking Spanish and he was speaking English in a way that maybe he (the doctor) gets irritated, I don't know. That was a problem, but the interpreter was very good. The only thing I see about that clinic is what the young woman told me. I had been very lucky that I got the interpreter because they only have two in the entire clinic.*
>
> *F: So you were able to communicate.*
>
> *M: Yes, I was able to communicate."*
>
> *F: Excellent, someone else?*

Language Access

The second area of investigation was titled “communication efficiency”, however, this may be a misnomer because the questions asked in this field actually referred to modes of interpretation provided by the facility, the use of family interpreters, and preference of the participant to the type of interpreting services used (See Appendix C).

Although researchers and the public often see having an interpreter as a solution to the language gap between a physician and a non-English speaking patient, the current literature show conflicting empirical evidence correlating the use of medical interpreters and variables such as patient satisfaction, adherence and follow up. One reason for these inconsistencies may be the fact that researchers are failing to see the importance of the wide variety of medical interpreters. A second explanation is that researchers have neglected contextual factors, such as doctor communicating style, but more importantly the organizational environment (Hsieh, 2003). By this, I mean that hospitals may have triage systems that are different from federally qualified health centers that have drop in policies. To non-English speakers or those unfamiliar with facility protocols, the standard procedures of triage in an emergency may room may be misconstrued as discrimination because of language, for example:

> *M: There was [an interpreter], but she got there after some time.*
>
> *F: About how long did you wait?*
>
> *M: About half an hour. We waited about half an hour. We took our baby to emergency. He was sick. We got there and asked for an interpreter. And I went and asked an Anglo (a Caucasian) woman, and she told me, yes, I will call you in a moment. I was waiting there and it was about half an hour later and in fact that day they did not help us there at the hospital.*
>
> *F: So, after waiting, they did not help you?*

M: Half an hour. No, they did not help us. We had to take him to another place.

W: We were waiting for more than an hour and they did not help us.

F: What reason? Are you able to share the reason they gave you? Or did they not give you a reason?

W: No, they just said everything was busy and they could not help us.

F: So, they refused to provide the service? In the end, where did you go for the service? Where did you go?

M: After waiting there for half an hour, the interpreter got there and this is what we were told. Um, there was no room. That there were lots of people, lots of people and that they could not help us (take care of us). So, we left and our son calmed down; he felt calmer. Then we took him to XXX Clinic with a doctor at the clinic and that is where the doctor took care of him. And we told the one who was going to care of him and he took care of (helped) us. He had a stomach infection.

F: So, he was sick.

M: He was sick and they did not help [take care of] us.

There are many different types of medical interpreters used in Idaho's health care facilities. These include paid professionals, volunteers, bi-lingual clinical staff, bi-lingual non-clinical staff, family and/or friends of the patient and language lines (phone interpreters). Our earlier study asked what type and how often some of these different services are used. There is some variability of use depending on the type of facility. Below is a breakdown by four different types of facilities.

ACUTE CARE HOSPITALS
(10 of 10 facilities reporting)

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff	20%	20%	60%		
b. Bilingual non-clinical staff	20%	10%	60%	10%	
c. Patient's family member/friend	20%	30%	30%	20%	
d. Interpreter: Internal Staff	55%	11%	11%	23%	
e. Interpreter: External Paid	30%	20%	20%	20%	10%
f. Interpreter: Volunteer		12%	12%	64%	12%
g. Language Line	30%	20%	30%	10%	10%
h. Other: (specify)					

Table 3: Acute Care Hospital Interpretation Method

CRITICAL ACCESS HOSPITALS
(13 of 26 facilities reporting)

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff	8%	23%	46%	23%	
b. Bilingual non-clinical staff	20%	10%	50%	20%	
c. Patient's family member/friend		25%	50%	8%	17%
d. Interpreter: Internal Staff		11%	11%	56%	22%
e. Interpreter: External Paid		22%	22%	56%	
f. Interpreter: Volunteer		30%	20%	40%	10%
g. Language Line					
h. Other: (specify)				67%	33%

Table 4: Critical Access Hospital Interpretation Method

CERTIFIED RURAL HEALTH CLINICS
(27 of 46 facilities reporting)

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff	17%	30%	17%	26%	10%
b. Bilingual non-clinical staff	15%	15%	40%	15%	15%
c. Patient's family member/friend	10%	20%	45%	20%	5%
d. Interpreter: Internal Staff	19%		6%	50%	25%
e. Interpreter: External Paid		29%		57%	14%
f. Interpreter: Volunteer		6%	11%	61%	22%
g. Language Line		21%	10%	53%	16%
h. Other: (specify)			7%	57%	36%

Table 5: Certified Rural Health Clinics Interpretation Method

FEDERALLY QUALIFIED HEALTH CENTERS
(7 of 10 facilities reporting)

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff	71%			29%	
b. Bilingual non-clinical staff	57%			43%	
c. Patient's family member/friend	14%	14%	29%	43%	
d. Interpreter: Internal Staff	33%		17%	33%	17%
e. Interpreter: External Paid			14%	57%	29%
f. Interpreter: Volunteer				71%	29%
g. Language Line				67%	33%
h. Other: (specify)				67%	33%

Table 6: Federally Qualified Health Centers Interpretation Method

Language Lines (telephone interpreter services) are shown to be used several times per week in all facilities except the Federally Qualified Health Centers. Our earlier study of Idaho facilities found that outside of the Acute Care Hospitals with more than 25 beds, the most prevalent language need is for Spanish (over 95%, see Table 1). The language line is the only interpreter service that does not have face-to-face contact. The effectiveness of this type of service is not perceived to be efficient.

> *No because anyway the person who is on the phone sounds like he/she is saying things really fast. Ah, he/she is telling you in a hurry – like say, is that everything or what? Because each question that he/she is asking you, he/she tells you, is that everything? And you ask again, and he/she asks you another question or you can, you ask another question and he/she goes ahead and tells the doctor and he/she tells you, is that everything? And it's like he/she are rushing the customer.*

There is a discomfort associated with having an interpreter that is not present to "see" the patient. Although the role of the interpreter is to act as the bridge between the doctor and the patient, there is a lack of trust that is associated with a non-present third party.

> *No because in addition, also, ah he/she is not looking to see where the problem is even though you tell him/her where the problem is, he/she does not, like the day that I was, that I went, ah, the doctor told him/her that it was regarding my knee. And I tell him/her I don't have anything in my knee…it's the ankle.*

Many Idaho facilities use interpreters that happen to bi-lingual clinical or non-clinical staff. They perform the interpreter function as an adjunct responsibility to their job. Their

primary job may range from being a registered nurse to a facility housekeeper, for example. The range of "comfort" or "trust" that this type of service was also variable.

> *I speak a bit of English, enough to stand on my own. But like the man says, often, interpreters are used to be sure of what is happening especially when you go to the dentist. It's often difficult to understand what you need for the children's. I am lucky, our dentist (mine and my girls) has a very good interpreter but she is the secretary.*
>
> *Well, it's a woman who does the cleaning there. They just call her to ask her, but she is not an interpreter. Yes [she was the housekeeper]. Then, she did not say what I was telling her, that I did not want them to do it (the test) because I had already eaten, that we could wait.*
>
> *No, they just grab them from where they are working. They bring them to interpret for you and that is it.*
>
> *They do have their interpreter at the clinic and yes the nurses, the nurses they have where I went here, it was in Ontario and, well there, yes, I felt calmer with that.*
>
> *Yes with him and supposedly there was a nurse, who is also an interpreter, but at the same time too (she) does not interpret well because….well they confused me.*

At times, this "confusion" was exacerbated by multiple interpreters, or multiple people trying to fill the void.

> *And then, the receptionist that only spoke English left. Then someone arrived, someone (a female) like Mexican and said, oh, I am sorry, she says, I did not know that you (all) did not speak English, then… It was someone else. It was someone else like a receptionist who did speak*

> *Spanish very well, because when we came in we saw her, but she let us in and then another Anglo woman came to take down the initial information.*
>
> *And again, and then again. And on the third time, then, the man was, it was a woman. Because the first time, it was a man and then the second time it was a woman, and then again, it was a man."*

Even when professional interpreters are used, there is the possibility of inadequate translation. Within the Spanish language exist many different dialects, and idiomatic terms are specific to the homeland of the Spanish speaker.

> *She had surgery; and got an interpreter, but I don't know if she was from El Salvador or from another place. She has a different way of speaking than us, than those of us who are Mexican…but, sometimes things my Mom was telling her, she did not say exactly what my Mom was saying… I don't know if it's due to the difference of expressing ourselves, we speak Spanish well; it is also Spanish but it's different, different way of saying things… This does not mean she is not a professional or that she did not, but she did not say exactly what my Mom was saying. Do you understand me?*

One case involved a patient who had some proficiency in English but not a full enough command to be able to directly communicate with the doctor. Therefore an interpreter was requested.

> *One time I had a professional interpreter and she was interpreting but she was not saying what I was saying…And I had that problem and in the end I told her Ma'am, why aren't you telling him/her what I say? Why are you telling him/her? She said, I don't understand you and I ask her, Aren't you a professional? Why are you here? Interpreting? You do not understand me? I need the interpreter because I do not understand but*

there are some things that I do understand and you are wrong and she got quiet and right away, the next appointment came. It was her; I reported her.

Another scenario for interpreters is the use of family members or friends. Most of the current literature on medical interpretation classifies this as the least desirable alternative because of the emotional and psychological ties to the patient. However, there were times that this was the only option and if the family member interpreter is a child, they are not taken seriously.

They called us and we waited for two hours for my daughter to be taken care of. But my boy would tell them to take care of her because she was very sick. They checked her temperature and they said she had a fever and they were very alarmed. But they continued visiting and laughing and laughing there at the hospital. They did not care.

"Trust" of the family member doing the interpreting often trumps medical knowledge or professionalism. In most cases where family members were used as interpreters, they were children. Below is a polling interchange with the Facilitator.

F: More trust, more trust? How old are the interpreters?

W: Mine is 15 years.

F: 15 years?

W2: 13 years.

F: 13 years? 13, okay, how about the rest?

W3: 16.

F: 16. Okay. And you feel you trust (them) more?

W: Can trust more.

W2: Yes, because we know that they are going to say what we are saying.

F: All right, and you also feel that they are interpreting.

W: Yes, it's the same. But we are being told daily, they are minors, and you should not take them as interpreters.

Health Outcomes

This line of questioning deals with the use of translated documents and written forms (See Appendix C). These documents include educational materials, consent forms and discharge instructions.

In many cases, educational materials are provided in both Spanish and English but these fluctuate depending on the type of material and the facility. From our earlier study, we found that the language most translated was Spanish.

Written Materials Translated into Other Languages	Percentage of Facilities using Written Materials	Specify Which Languages
a. Consent Form	83%	Spanish
b. HIPAA Information	81%	Spanish
c. Patient Registration	66%	Spanish
d. Patient Education Materials	87%	Spanish
e. Financial Assistance Information	72%	Spanish
f. Discharge Planning Instructions (e.g. prescription or home care instructions).	57%	Spanish
g. Patient Satisfaction Survey	30%	Spanish
h. Other - Includes immunization information; patient transfer forms and advanced directives		Spanish

Table 7: Written Materials Translated into Other Languages

When asked about educational materials or instructions, in many cases the materials were available.

> *If you ask for it, they will send it in Spanish. Well, often you are asked, do you want it in Spanish? There are some clinics that do have these in English on one side and in Spanish on the other side. The last clinic I went to, nothing is available in Spanish.*

However, when the initial intake and informed consent are requested, there was confusion. While 83% of facilities reported that they had Spanish language informed consent forms, the question of whether the patient actually knew what he/she was signing is questionable.

> *For example, everything is in English when filling out the consent form, so we sign because we have to so that they can begin the paperwork there. We don't even know what we are signing because we don't understand it. There are clinics that have it in English on one side and Spanish on the other side.*

The effect of health literacy is the critical question here. Regardless if the materials are available in Spanish or not, it is not relevant if the patient does not understand what he or she is signing. It is here that a trained interpreter's role has heightened importance.

> *I did not understand them. I liked having the interpreter because there were some things, some professional words that are words that we do not use daily.*

Instructions at discharge and follow up are always given verbally by the doctor but it was felt that written forms of the instruction in Spanish were helpful reminders. While this was seen

as a very positive thing, there were occasions were the translated instructions were not readily available and there was a breakdown in getting them to the patient.

> *Yes, because when they are telling you, you…but when you leave, oh, what did he/she tell me? They were going to send me all of the forms that way, but I never sent them to me. I don't know if it's because they do not have them in Spanish. They did not send me anything.*

In our medical system, the continuum of care does not stop after diagnoses and prescription. If there is a "disconnect" between doctors and pharmacy departments for example, the burden of miscommunication is once again placed upon the patient. Once the patient leaves the doctor's office and goes onward, he or she encounters barriers in the new setting. And once again, it depends on the pharmacy.

> *And the point is that they give you the medicine but they never tell you how you are going to take it…and once I got mad (angry) because I saw a woman; she took her sick son to the doctor and they gave her the prescription and she went to fill the prescription. They gave it to her. The same thing has happened to me. And so, I got mad (angry) because the woman did not understand anything. She did not understand what the prescription said. She asks, how should I give it to him? Didn't they tell you, Ma'am? She said, they did not tell me.*

> *There are clinics where it is in Spanish; XXXXX has them that way. There you choose Spanish or English. You push indicating if you want it in Spanish and they give it to you in Spanish. Then, they tell you how you*

> *should take it and that. But there are pharmacies, an example is this clinic that I went to; it's just English and that's the problem that what they stick to it is just in English.*

Beyond being unable to read a prescription, there is the possibility of communication error between the doctor and the pharmacy on the type of medication that is prescribed. If a common language is understood, then these errors can be easily remedied. When the pharmacist and the patient do not speak the same language, a simple error can escalate into a long drawn out process.

> *It happened to me once. The doctor prescribed some eardrops. At the pharmacy, they were giving me eye drops; then…I told the man who was there, by signing (sign language) you try to get them to understand you…that I did not have a problem with the eyes, but the ears. And then I said, "What do I do?" Oh, sorry, sorry, that's the way things are. I like to be informed about medication before…I don't know. There are many individuals who are given things and they gave them to me, they will apply on their eyes, they apply them in the ears.*

> *There are never interpreters available at the pharmacies. There are no interpreters there. No. There is one here at XXXX (clinic); there is a Latino there. That man has such a temper ay ay ay. You go and leave him the prescription there and he gives it to you until the following day. Because if you go, he tells you, do not be bothering me. Come for your prescription tomorrow. That way, that way, but, rudely.*

Potential for Medical Errors

We asked the question, "Do you feel the difference in languages impacts how well your provider understands your medical needs and/or concerns? The respondents felt that the ability to communicate their needs and concerns to medical professionals was very high on their list. Accurate translation in matters that could represent life altering treatment or self-management was critical.

> *I hurt here in this part of the body, just below the liver, the kidney, the heart. Because can you imagine like your not knowing English, how am I going to tell him/her, how do you say kidney, it hurts right here. If I only say it hurts right here….they may think I am talking about the ribs. They imagine, they might start imagining. Then, what I, right now, like Nacho says, he speaks a little Spanish, I speak a little English or in other words, that we talk little (Spanish, English) between the two of us or I know that he understands and what he wants to understand and I say what I want to say but in the end we do not understand each other.*

The role of the interpreter, as a bridge to communication, is taken very seriously. Many of the participants in this study had some grasp of the English language. It was often felt that although an interpreter was present that they were not able to translate accurately. This again, lent to the feeling of mistrust or discomfort with the system.

> *Someone was interpreting for her but was not interpreting correctly. They gave her so much medicine that when she went to another doctor she told us that that doctor wanted to do surgery because her illness was serious and the other doctor said it was due to so much medicine,*

> *And he says, why is this man, who is the interpreter here, why did he not explain it to me the way you are explaining it to me? I tell him what happens it's that they believe that by knowing a little Spanish, they think that that makes them a good interpreter. But an interpreter should be well trained.*

Health Service Utilization

A perceived barrier among respondents is the effect of asymmetric information between the doctor and the patient. The usual role that a patient adopts in a medical encounter is to acquiesce to the medical professional because that professional has more training in treatment. While the patient has a more intimate knowledge and history of his/her illness, western medicine still practices in a patriarchal format. This model is one of patient-doctor interaction under asymmetric information (Lee, C, 1995).

For our participants, this gap in relational communication is further widened by the gap in language. The roles become more accentuated until the provider role is perceived as condescending. At times, there was a feeling of inadequacy and humiliation because of the language barrier. Rather than a patient-centered relationship with the doctor/interpreter, the patient felt as if they were being scolded for not being to communicate.

> *Scolding yes; because I did not know how to explain anything. And well since then, we cannot go like that because; well we need to look for someone to interpret for us. Because [if] it's like not going, right? You will not be assisted (by them).*

Another influencing factor in the type of barriers perceived in this study is the effect of low socioeconomic status. Of the 15 focus group participants, only four had an annual income of over $20,000. Indeed, three made less than $10,000. In a systematic review of the literature, it was found that patients' socio-economic status influences doctor-patient communication. Results show that patients from lower social classes receive a more directive and less participatory consulting style, characterized by significantly less information giving, less directions and less socio-emotional and partnership building from their doctor. Patients from lower social classes are often disadvantaged because of the doctor's misperception of their desire and need for information and their ability to take part in the care process. Combining that with the language barrier, it is difficult for doctors and patients to develop a contextual relationship which would empower patients to express concerns and preferences (Willems S, De Maesschalck S, Deveugele M, Derese A, & De Maeseneer J. 2005).

Lack of respect afforded them by other Hispanics was consistently noted as a third barrier by participants. This issue was perceived as hurtful and disappointing, and elicited more vociferous responses that superseded discussion of other topics.

Discussion and Analysis

Earlier, we offered the Health Belief Model as a useful theoretical framework for analysis. The previous sections have provided the reader with insights through an abundance of anecdotes. However, a stated goal of this project was to take the findings from this study and translate them into concrete actions or policies.

To briefly review the model, it is a simple equation whereby perceived benefits of performing an action must be more relevant to an individual’s consciousness than perceived

barriers to performing that action for the action to occur. Within this model, there are "modifying factors" that influence an individual's perception of those benefits and/or barriers.

Modifying factors include categories such as demographics (age, race, sex, etc.), socio-psychological (social class, personality, peer or reference group, etc.), and cues to action (media, medical advice, reminder systems, other peer group members' experience). Some of these items are mutable. Others are not. Yet all of them have some explanatory power in examining perceived benefits or barriers.

The action we are trying to achieve is the proper use of medical services and compliance with doctors' advice. It is a basic assumption of this project that performing the action results in better health outcomes. It is hypothesized that a effective communication enhances the probability of the action.

Effective and accurate communication is a fundamental aspect of a health care encounter between a patient and a provider. Language barriers can often lead to misunderstanding, less patient satisfaction and may lead to lack of compliance with prescribed medical treatment. Quality health care requires the availability of language services be available and provided by competent staff. The participants in these focus groups voiced concern about not receiving adequate care because of the inability to communicate with health care providers.

They also described instances when the interpreter and doctor seemed uncomfortable during an encounter. Participants were more likely to leave with a low patient satisfaction and reported that they were less likely to follow-up or return for more health care services. Focus group participants were also, less satisfied with their health care encounter when no interpreter or untrained interpreters were used. Focus group participants reported a higher patient satisfaction

when both verbal and written material was available in Spanish and when family member and friends interpreted for them. The least favorable language service was the use of telephone language line, because of the inability to make a personal connection with the person on the phone. It is evident from the transcripts that communication-related problems may interfere with the ability to establish a trusting relationship with Spanish speaking patients. Cultural perspective may also play a role.

A patient's health beliefs can arise from normative cultural values, along with personal experience. Hispanics share some basic cultural values; they typically place a high value on interpersonal relationships. ***Respeto***, ***simpatía*** and ***personalismo*** are common group norms that can influence an individual's perception, values and behaviors.

Respeto (respect) refers to a quality of self that must be presented in all personal relationships. It signifies attention to proper and moral behavior and indicates an expression of deference to the person one encounters. Differential treatment towards others is determined on the bases of sex, social position, economic status, and position of authority (Karliner S, Crewe SE, Pacheco H, and Gonzalez , 1988).

Because the Health Care Providers are automatically viewed as authority figures, ***respeto*** may result in any number of communication barriers, from the hesitation to ask questions, or to disagree with the treatment plan of care. It can also lead to patients stating they understand a medical regiment when they do not because they do not want to hurt the provider's feeling. The absence of ***respeto*** may potentially lead to inaccurate medical histories, medical errors, or adherence to treatment plan.

Hispanics place a high value on ***personalismo*** (personalized) and personal interaction is an important part of gaining a patient's trust. Warm personal greetings, handshakes, and taking a personal interest in the patient's life are essential to gaining a patients trust.

Simpatia (kindness) places value on respect and kindness in social interactions despite stressful or hostile situations. Many Hispanic cultures consider it more proper to smile and diffuse a stressful situation rather than charge ahead into heated argument. Direct disagreement with a provider is uncommon; the usual response to a decision with which the patient or family disagrees is silence and noncompliance (B. D. Smedley, A. Y. Stith, and A. R. Nelson).

The perception of these focus group participants may be partly related to differences in knowledge, personal experience, and cultural normative values. The health care provider, the interpreter and the patient each have their own expectations, they bring in their own unique perspective and biases to the medical encounter. Lack of understanding of the differences in knowledge, cultural values, and personal experience, between the three individuals can lead to miscommunication that can be expressed as frustration, confusion, and, at times, anger. These differences may account for the perceived lack of respect from other Hispanics who serve Spanish-speaking patients.

Focus group participants also expressed concern regarding the cost associated with accessing health services. Inconsistency in their perceived quality of health care was at time viewed by focus group participants as a result of their socio-economic status, lack of insurance, and citizenship status.

Recommendations

These recommendations are made specifically to the State Office of Rural Health and Primary Care (SORH). It is recognized that the needs and experiences of each locally operated facility requires specificity in planning, however these recommendations are made from the perspective of what role the SORH can play from a statewide perspective. The following recommendations are made in addition to ones made earlier to the SORH after the first study, "Determining the Need and Effectiveness of Current Linguistic Services in Idaho's Healthcare System" was completed. There may be some overlap, but they are not contradictory of the earlier findings. Indeed, they are supportive.

1. Develop a general cultural competency module for front line health care providers and staff (including receptionists, intake nurses).
2. Develop a community education module in Spanish that explains the differences in Idaho's health care delivery systems (clinics, EDs, FQHCs, etc.).
3. Work with providers to translate basic forms into Spanish, including patient satisfaction surveys.
4. Collaborate with universities to offer Continuing Education Units (CEUs) for a practical and basic medical terminology Spanish course for health care providers.

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Appendix A: Flyer *(Spanish)*

¡¡¡¡ATENCIÓN!!!!

POR FAVOR AYÚDENOS A COLECTAR INFORMACIÓN QUE PODRÍA AYUDAR A MEJORAR EL ACCESO A LOS SERVICIOS MÉDICOS PARA LOS LATINOS EN IDAHO

El Centro de Comunidad y Justicia en colaboración con la Oficina del Estado de Idaho sobre la Salud en Áreas Rurales y la Atención Inicial (del paciente) están tratando de colectar información sobre los problemas del idioma de la perspectiva de las personas hispanohablantes quienes han recibido servicios médicos y tuvieron que utilizar los servicios de un intérprete.

El propósito del proyecto es de identificar la extensión hasta la cual las personas hispanohablantes que utilizan los servicios de atención médica identifican el idioma como una barrera (un obstáculo) para poder recibir la atención (o los servicios).

Para lograr las metas (los objetivos) de este proyecto el Centro propone desarrollar y llevar a cabo dos Grupos Principales en español:

-Uno (1) en Fruitland en el Centro Comunitario (Community Center, en inglés) el día viernes, 9 de febrero del 2007 desde las 6:00 de la noche hasta las 8:00 de la noche.

-Uno (1) en Nampa en el Centro Cultural Hispano de Idaho (Hispanic Cultural Center of Idaho, en inglés) el día sábado, 10 de febrero del 2007 desde las 12:00 del mediodía hasta las 2:00 de la tarde.

Cada grupo principal se limitará a ocho (8) participantes, con el grupo ideal compuesto de por lo menos 4 participantes mujeres y 4 participantes hombres, si es posible.

Todos los participantes deben tener 21 años de edad o mayores y deben haber utilizado los servicios de un intérprete médico en Idaho durante los últimos 6 meses.

Se le pagará un estipendio (una beca) de $50 a cada participante que complete la sesión del grupo principal.

Para participar, por favor de comunicarse con Sam Byrd o Mari deLeón al 208-378-1368 o gratis de larga distancia al 1-800-427-9072 NO MÁS TARDE DEL DÍA LUNES, 5 DE FEBRERO DEL 2007.

Appendix A: Flyer (English)

¡¡¡¡ATTENTION!!!!

PLEASE HELP US COLLECT INFORMATION THAT COULD HELP IMPROVE HEALTH CARE ACCESS FOR LATINOS IN IDAHO

The Center for Community and Justice in collaboration with the Idaho State Office of Rural Health and Primary Care is seeking to collect information about language issues from the perspective of Spanish speaking individuals who have accessed health services where an interpreter was used.

The purpose of the project is to identify the extent to which Spanish-speaking users of healthcare service identify language as a barrier in receiving care.

To accomplish the goals of this project the Center proposes to develop and conduct two Focus Groups in Spanish:

-One (1) in Fruitland at the Community Center on Friday, February 9, 2007 from 6:00 p.m. to 8:00 p.m.

-One (1) in Nampa at the Hispanic Cultural Center of Idaho on Saturday, February 10, 2007 from 12:00 noon to 2:00 p.m.

Each focus group will be limited to eight (8) participants, with the ideal group being composed of at least 4 females and 4 male participants, if possible.

All participants must be 21 years of age or older and must have used a medical interpreter in Idaho within the last 6-months.

Each participant completing the focus group session will be paid a stipend of $50.

To participate please contact Sam Byrd or Mari de Leon at 208-378-1368 or toll free at 1-800-427-9072 NO LATER THAN FEBRUARY 5, 2007.

Appendix B: Consent Form (Spanish)

FORMULARIO DE CONSENTIMIENTO

Contactos:

L. Samuel Byrd
Centro de Comunidad Y Justicia
106 W. 43rd Street
Garden City, Idaho 83714
(208) 378-1368
FAX: (208) 336-5327
sbyrd1@mindspring.com

Mari DeLeón
Centro de Comunidad Y Justicia
106 W. 43rd Street
Garden City, Idaho 83714
(208) 378-1368
FAX: (208) 336-5327
mdeleon@comunidadyjusticia.org

PROPÓSITO DEL ESTUDIO

El propósito del proyecto es de identificar la extensión hasta la cual las personas hispanohablantes que utilizan los servicios de atención médica identifican el idioma como una barrera (un obstáculo) para poder recibir la atención (o los servicios).

RIESGOS, ESTRÉS, O INCOMODIDAD

Algunas personas sienten que proporcionar información para un proyecto de grupo principal es una invasión de privacidad. Algunas personas se sienten un poco cohibidas cuando ellas hablan dentro de un grupo de personas. Algunas personas se sienten un poco cohibidas cuando se les graba por medio de cinta (magnética). Hemos abocado las preocupaciones sobre su privacidad en la siguiente sección de este formulario de consentimiento.

ALTERNATIVAS DE TOMAR PARTE EN ESTE ESTUDIO

Tomar parte en el grupo principal es voluntario. Usted puede dejar de hacerlo en cualquier momento.

OTRA INFORMACIÓN

El equipo de investigación mantendrá la información del estudio confidencial. Codificaremos la información del estudio. Mantendremos la relación entre su nombre y el código en un sitio seguro y separado hasta el día 30 de junio del 2008. Si los resultados de este grupo prinicipal se publican ó se presentan, no usaremos su nombre.

Aunque el equipo de investigación tomará precauciones para salvaguardar su privacidad, no podemos garantizar que todos los participantes del grupo principal no repetirán la información presentada durante la discusión del grupo principal.

Es posible que yo quiera comunicarme de nuevo con usted para poder aclarar información de su entrevista. Por favor indique abajo si me da o no su permiso para comunicarme de nuevo con usted. Al dar su permiso para comunicarme de nuevo con usted, esto no lo obligará a usted de ninguna manera.

Este formulario de consentimiento se retendrá por el proyecto como documentación de su consentimiento para participar pero no se asociará con sus respuestas a ninguna de las preguntas.

Nombre en letra del facilitador Firma del facilitador Fecha

Declaración del sujeto

Se me ha explicado este estudio a mí. Ofrezco tomar parte en esta investigación. He tenido una oportunidad de hacer preguntas. Si después tengo preguntas sobre la investigación puedo hacerle preguntas a uno de los investigadores listados arriba. Si tengo preguntas sobre mis derechos como un sujeto de investigación, puedo llamar al Centro de Comunidad y Justicia (208) 378-1368. Recibiré una copia de este formulario de consentimiento.

_____Doy mi permiso para que el investigador se comunique de nuevo conmigo para aclarar información.
_____NO doy mi permiso para que el investigador se comunique de nuevo conmigo para aclarar información.

Firma del sujeto Nombre del sujeto en letra de molde Fecha

cc: Expedientes del Investigador
Sujeto

Appendix B: (English)
Consent Form

Contact information:

L. Samuel Byrd
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106 W. 43rd Street
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PURPOSE OF THE STUDY

The purpose of the medical language focus group the extent to which Spanish-speaking users of the healthcare services identify language as a barrier in receiving care.

RISKS, STRESS, OR DISCOMFORT

Some people feel that providing information for a focus group is an invasion of privacy. Some people feel a little self-conscious when they speak in a group of people. Some people feel a little self-conscious when they are audiotaped. We have addressed concerns for your privacy in the following section of this consent form.

ALTERNATIVES TO TAKING PART IN THIS STUDY

Taking part in the focus group is voluntary. You can stop at any time.

OTHER INFORMATION

The research team will keep the study information confidential. We will code the study information. We will keep the link between your name and the code in a separate, secured location.. If the findings of this focus group are published or presented, we will not use your name.

I may want to re-contact you in order to clarify information from your interview. Please indicate below whether or not you give your permission for me to re-contact you. Giving your permission to re-contact you does not obligate you in any way.

This consent form will be retained by the project as documentation of your willingness to participate but will not be associated with your responses to any of the questions.

Printed name of facilitator Signature of facilitator Date

Subject's statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later on about the research I can ask one of the investigators listed above. If I have questions about my rights as a research subject, I can call Centro de Comunidad y Justicia (208) 378-1368. I give my permission for the researcher to audiotape my participation in the focus group as described above in this consent form. I will receive a copy of this consent form.

_____I give my permission for the researcher to re-contact me to clarify information.
_____I do NOT give my permission for the researcher to re-contact me to clarify information

---

Signature of subject Printed name of subject Date

cc: Investigator's File
Subject

Appendix C: Focus Group Questions (Spanish)

Preguntas de Discusión para el Grupo Principal (LEP) de Habilidad Limitada del inglés
Propósito: Identificar el grado al cual los Hispanohablantes que usan los servicios de atención médica identifican el idioma como una barrera (un obstáculo) para recibir la atención (los servicios).

Calidad General de la Última Experiencia Reciente	Eficacia de la Comunicación	Formas de Comunicación	La Importancia de los Servicios de Intérprete	Barreras Percibidas
¿Puede usted describir sus experiencias recibiendo servicios de atención médica durante los últimos seis meses? ¿Ha tenido usted experiencia usando intérpretes que su proveedor de atención médica (servicios médicos) le ofrecen a usted? Si así es, ¿es este un método efectivo de comunicación entre usted y su proveedor de atención médica (servicios médicos)?	¿Cómo le comunica usted sus necesidades o preocupaciones de salud cuando usted y su proveedor de atención médica (servicios médicos) hablan idiomas distintos? (línea (telefónica) de idioma, familia, personal bilingüe, intérprete profesional) ¿Cuál es el método de servicios de intérprete que usted prefiere para tener acceso a la atención médica (servicios médicos)? ¿Cuál es el método que usted menos prefiere? Si alguna vez a usado a un miembro de la familia (familiar) como su intérprete médico, ¿cómo se siente acerca de usar a los miembros de la familia (familiars) como su intérprete médico?	¿Le da a usted su proveedor de atención médica (servicios médicos) información médica (formularios (formas) de consentimiento, materiales educativos de pacientes, formularios (formas) de asistencia financiera, etc.) o instrucciones para el cuidado de seguimiento (recetas, pruebas de laboratorio, terapia física, etc.) <u>por escrito</u> en español? ¿Le da a usted su proveedor de atención médica (servicios médicos) información médica o instrucciones de cuidado de seguimiento <u>verbal</u> en español? ¿Cuál método (oral o escrito) es más efectivo para ayudarle a usted a entender las instrucciones o el tratamiento médico que se le da a usted por su proveedor de atención médica (servicios médicos)?	¿Siente usted que las diferencias del idioma impactan que tan bien entiende su proveedor sus necesidades o preocupaciones de atención médica (servicios médicos) de usted? ¿Siente usted que las diferencias del idioma impactan que tan bien usted puede comunicarle sus necesidades de salud de usted a sus proveedores de atención médica (servicios médicos)?	¿Alguna vez ha sentido usted que usted necesitaba los servicios de intérprete médico pero no los recibió? ¿Alguna vez ha evitado o se ha tardado ir a una cita médica porque no había servicios de intérprete? ¿Hay algo más que le gustaría a usted compartir con nosotros sobre el problema de las barreras (los obstáculos) del idioma y la atención médica (los servicios médicos)?

Appendix C: Focus Group Questions (English)

Discussion question for the Primary Group of Limited English Proficiency (LEP)
Goal: Identify the level at which Spanish-speaking individuals who use medical services, identify language as a barrier to receiving attention.

General Quality of Most Recent Experiences (Patient Satisfaction)	Communication Efficiency (Reduce potential for Medical Errors)	Forms of Communication (Access)	The Importance of Translating Services (Health outcomes)	Perceived Barriers (Health Service Utilization)
Could you please describe your experiences receiving medical attention in the last six months? Have you had experiences using translators that your medical service provider has offered you? If so, is this an effective method of communication between you and your medical service provider?	How do you communicate your health needs or concerns when you and your medical service provider speak different languages? (telephone system, family, bilingual personnel, professional translators) Which method of translating services do you prefer to have access to when receiving medical attention? Which method do you prefer less? If you have ever used a family member as your translator, how do you feel about using family members as your translators?	Does your medical service provider provide you with medical information, consent forms, educational materials for patients, financial assistance forms, or written instructions on follow-up procedures, prescriptions, physical therapy, etc., in Spanish? Does your medical service provider provide you with medical information or follow-up instructions, in Spanish verbally? Which method (written or oral) is more effective in helping you understand the instructions or medical treatment that is given to you by your medical service provider?	Do you feel the difference in languages impacts how well your provider understands your medical needs and/or concerns? Do you feel the difference in languages impacts how well you can communicate to your medical service provider, your medical needs and/or concerns?	Do you feel you ever needed medical translating services, but never received them? Have you ever avoided or put off a medical appointment because there were no translating services? Is there anything else you would like to share with us about problems with language barriers and medical services/attention?